MAHAJAN IMAGING & LABS

A unit of Mahajan Imaging Pvt. Ltd.
C-6/8, Safdarjung Development Area,
New Delhi-110016 ☎ 011-4118 3838
info@mahajanimaging.com
www.mahajanimaging.com
CIN: U85199DL1999PTC101010

Visit No.	: 182311100054	UID No.	: 2152671
Patient Name	: **Mr. S C ANAND IPID NO- 138040**	Reg. Date	: 10/Nov/2023
Age/Sex	: **77 YRS / Male**	Report Date	: 13/Nov/2023
Referred By	: Dr. MANOJ KUMAR	Print Date	: 13/Nov/2023

FDG WHOLE BODY PET CT SCAN

Whole body FDG PET CT scan was performed from the vertex to mid-thigh on a United Imaging uMI 550 digital PET CT system without breath hold instruction following intravenous injection of ^{18}F- fluorodeoxyglucose through an IV line. Patient was asked to rest quietly for 60 +/- 15 minutes in a shielded room to allow tracer to accumulate in the body. High resolution CT scan was performed during this examination on a 80 slice MDCT with intravenous injection of non ionic contrast – Iohexol 50 ml followed by PET images. Additional breath hold CT was performed for evaluation of the lungs. The semi-quantitative analysis of FDG uptake was performed by calculating SUV (Standardized uptake value) corrected for the administered dose and patient body weight. The creatinine level of the patient was 0.89 mg/dl and blood sugar level was 129 mg/dl at the time of tracer injection. No adverse reaction was observed during the scan.

Patient is being evaluated for lesion in the liver with portal vein thrombosis, detected on recent CECT abdomen with raised serum AFP. PET CT scan is being done for further evaluation.

The overall bio-distribution of FDG is within normal physiological limits.

Brain: The brain parenchyma is unremarkable with normal FDG bio-distribution. No significant focal lesion or abnormal focal FDG uptake noted.
It may kindly be noted that all brain metastases may not be apparent on a PET CT scan and an MRI head may be performed where clinically indicated.

Head & Neck: *Non FDG avid mucosal thickening of right maxillary sinus is noted.*

Dental implants are noted in situ causing metallic streak artifacts with resultant image degradation.

The thyroid gland is unremarkable with normal homogenous attenuation on CT scan and no abnormal FDG uptake.

No significant FDG avid cervical lymphadenopathy is seen.

Thorax: *Few non FDG avid small calcified nodules are noted in the left lung. A non FDG avid tiny nodule is noted in the upper lobe of right lung, likely non-specific.* There is no evidence of any significant FDG avid parenchymal lesions.

Multiple mildly FDG avid and non FDG avid mediastinal and hilar lymph nodes are noted, likely reactive / inflammatory. Non FDG avid sub-centimeter sized anterior phrenic and paraesophageal lymph nodes are noted.

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Bilateral minimal pleural thickening is noted.

Abdomen: *The liver is enlarged measuring approximately 17.4 cm in maximum craniocaudal extent with nodular outline. Transient hepatic attenuation defect is noted in the right lobe of liver.* **Mildly FDG avid (SUV Max: 4.7) heterogeneously enhancing subcapsular hypodense soft tissue lesion is noted in segment VII of liver, compressing the intrahepatic IVC, infiltrating into the right hepatic vein reaching upto the supra-hepatic IVC and branches of right portal vein, measuring approximately 2.9 x 3.3 x 4.9 cm in size. Right portal vein and its branches are dilated. FDG avid (SUV Max: 7.0) filling defect suggestive of thrombus is noted in the right portal vein and its branches, left and main portal veins.** *Few hyperdense calculi are noted in the gall bladder lumen (USG is the modality of choice to rule out GB stones).*

Few non FDG avid sub-centimeter sized lymph nodes are noted adjacent to the supra-hepatic IVC.

The spleen is unremarkable and demonstrates normal physiological FDG uptake. No focal lesion is seen. The pancreas appears unremarkable with no abnormal FDG uptake.

Both adrenal glands are unremarkable with no evidence of any abnormal FDG uptake.

A non FDG avid sub-centimeter sized hypodense cyst is noted in the interpolar region of right kidney. Few hyperdense calculi are noted in the middle and lower calyces of right kidney. Bilateral kidneys are otherwise unremarkable with no evidence of any abnormal FDG uptake.

Atherosclerotic calcifications are noted in abdominal aorta and its major branches.

Hiatus hernia is noted. The stomach is otherwise unremarkable.

The small bowel loops are unremarkable. *Inhomogeneously increased FDG uptake is noted in the long segment of large bowel loops, ?Physiological / ?Inflammatory. Few diverticuli are noted in the ascending colon.*

Mildly fat stranding is noted along the celiac axis, its branches and superior mesenteric artery.

Few non FDG avid sub-centimeter sized periportal and retroperitoneal lymph nodes are noted. No significant FDG avid pelvic lymphadenopathy is seen.

Minimal free fluid is noted in the perihepatic region and in the pelvis.

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CIN: U85199DL1999PTC101010

NABH ACCREDITED

Visit No.	: 182311100054	UID No.	: 2152671
Patient Name	: **Mr. S C ANAND IPID NO- 138040**	Reg. Date	: 10/Nov/2023
Age/Sex	: **77 YRS / Male**	Report Date	: 13/Nov/2023
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Non FDG avid subcutaneous stranding is noted in the anterior abdominal wall.

The urinary bladder is partially distended and is unremarkable.

The prostate gland is mildly enlarged in size. Suggested: Serum PSA correlation.

Few calcified granulomas are noted in the right gluteal region.

Few scrotal calcifications are noted.

Skeleton: *Degenerative changes are noted in the spine.* The visualized bones are otherwise unremarkable with no evidence of any abnormal FDG uptake.

OPINION: PET CT scan findings are suggestive of mildly FDG avid heterogeneously enhancing subcapsular hypodense soft tissue lesion in segment VII of liver, infiltrating into the right hepatic vein, reaching upto the supra-hepatic IVC and branches of right portal vein with FDG avid tumor thrombus in extra and intrahepatic portal veins with minimal ascites as described above. Suggested: Histopathological correlation

Please correlate clinically.

(Please note: ^{18}FDG PET CT scan cannot differentiate between mitotic and infective pathology. Histopathology is suggested for confirmatory diagnosis).

Dr. Parul Mohan	**Dr. Amit Bhoil**	***Dr. Nikhil Seniaray**	**Dr. N.H.V. Rayudu**
Sr. Consultant	**Sr. Consultant**	**Consultant**	**Resident**

(Please carry report and CD on your next visit for comparison).
(In case of any typographical error please inform immediately and get it corrected within 7 days).

Fortis Flt. Lt. Rajan Dhall Hospital

Sector B, Pocket 1, Aruna Asaf Ali Marg
Vasant Kunj, New Delhi-110070

Patient Name: Mr. S C Anand
Registration No: 1218184
Diagnosis:
Age/Sex: 77 Yrs/M
Ref By: Dr Manoj Kumar
Date: 07-11-2023 09:55:00 AM
Procedure: UGI Endoscopy

GASTRO-DUODENOSCOPY REPORT

Indication:

Findings

Esophagus: Large varices.
GE junction at 40 cm.

Stomach: Severe edema and erythema.

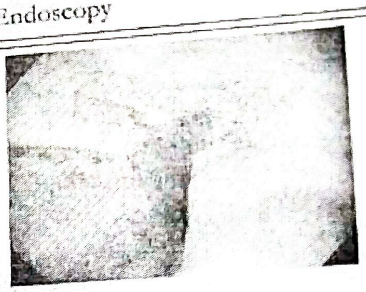
Duodenum:

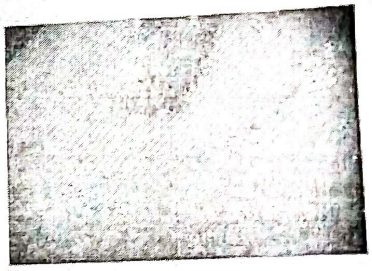
First part: Normal

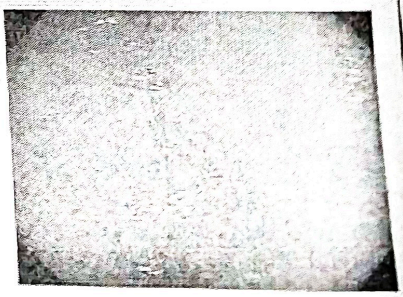
Second part: Normal

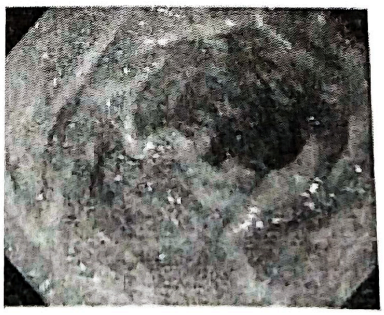
Conclusions: **Large esophageal varices with severe PHG.**

Biopsy: Not taken









Dr Manoj Kumar
(Gastroenterology)

Fortis Flt.Lt. Rajan Dhall Hospital

Sector B, Pocket 1, Aruna Asaf Ali Marg
Vasant Kunj New Delhi-110070
Phone No. – 01142776222

FibroScan®

FORTIS HOSPITAL
VASANT KUNJ

SmartExam: ON

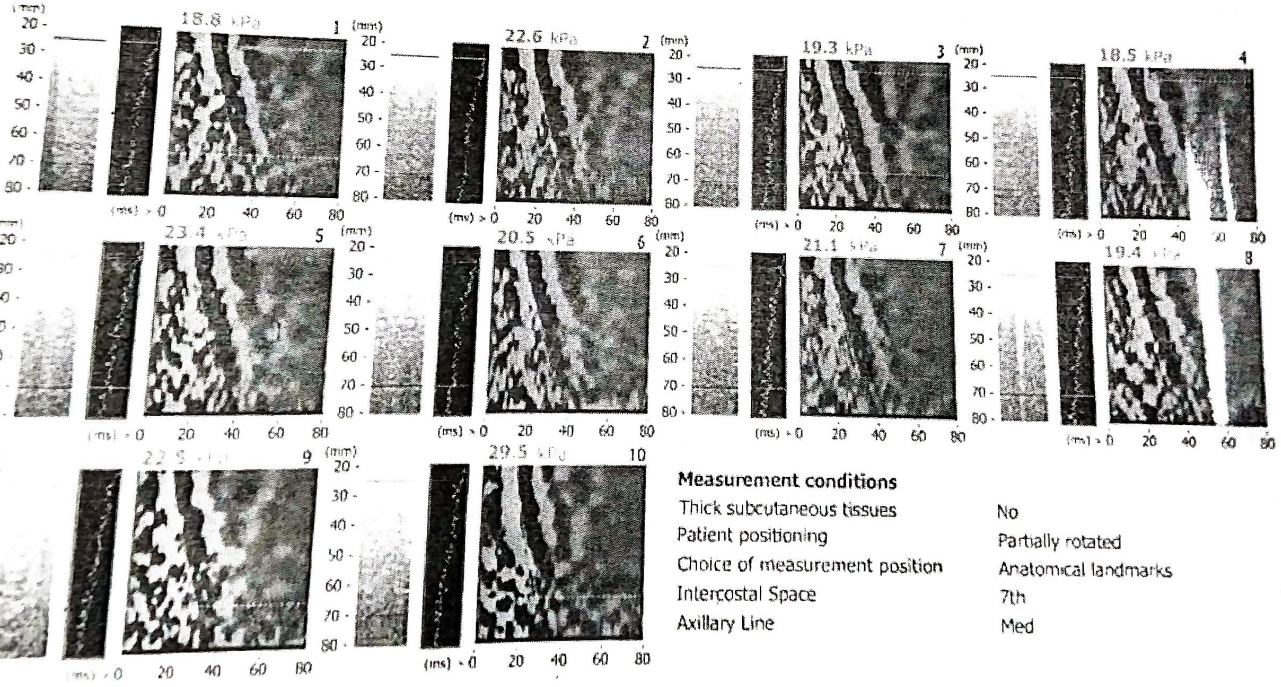
MR S C ANAND

M

1218184
Height:
Weight:
Physician: DR MANOJ KUMAR
Others
Fasting: Yes

	SD	CAP (dB/m)	E (kPa)	
		MEAN	MEDIAN	IQR/Med
	20	244	20.8	16%

07/11/2023 10:09:17
Exam: M
SWF = 50Hz
Organ: Liver
Operator: Operator
E-MEASUREMENTS: 10
CAP-LEVEL: >100 %



Measurement conditions

Thick subcutaneous tissues	No
Patient positioning	Partially rotated
Choice of measurement position	Anatomical landmarks
Intercostal Space	7th
Axillary Line	Med

Software release number F5.4.1.5.1

FibroScan® is a medical device intended as an aid for the management of patients with liver disease. Measurements should be performed by a certified operator. The values obtained must be interpreted by a physician experienced in dealing with liver disease, taking into account the complete medical records of the patient, the number of valid measurements and their dispersion. Probes must be calibrated according to the manufacturer's recommendations.

echosens™

Dr. Manoj Kumar
(Gastroenterology)

Dr Vineet Kr Gupta
(Gastroenterology)

(2)

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☎ 011- 42776222 Ext. 5813, 5815
info@mahajanimaging.com
www.mahajanimaging.com
CIN : U85199DL1999PTC101010

Patient Name	:	S C Anand	Scan Date	:	06-11-2023
Sex	:	M	Patient ID	:	1218184
Age	:	77Y 5M 25D	Modality	:	CT
Accession No.	:	IP.27428915	Ref Physician	:	Dr. Manoj Kumar

CECT WHOLE ABDOMEN (TRIPLE PHASE)

The triple phase examination was conducted on a multi-slice multidetector CT (MDCT) scanner. Serial axial sections were obtained after IV injection of 80 ml of non-ionic contrast (Omnipaque 350mg/ml) at a flow rate of 4.0 ml/second. KFT – Serum creatinine 0.80mg/dL. Scan in triple phase of liver were obtained and evaluated. No contrast reaction was observed.

Clinical profile: *Shortness of breath.*

FINDINGS:

The liver is normal in size and measures approximately 13.7cm craniocaudally. There is evidence of ill-defined hypodense area with mild enhancement in the porto-venous phase with washout in the delayed phase seen in segment 7 of liver, abutting the posterior capsule, this measures approximately 57 x 28mm and appears to be infiltrating into the IVC hepatic vein confluence. The rest of the hepatic and intrahepatic IVC show patent lumen. Transient subcapsular arterial phase enhancement is noted in the liver parenchyma – likely due to perfusion variation. The liver shows mild surface nodularity.

Evidence of hypodense enhancing filling defect seen in portal vein causing expansion of portal vein, extending to right and left branches and the peripheral branches. Arterial phase enhancement is seen in the periphery of the lumen of the vessel. The splenic vein and superior mesenteric veins show patent lumen.

Gall bladder shows multiple calculi.

The spleen is normal in size (9.2mm) and attenuation.

Pancreas is normal in size, attenuation and contour. No focal lesion seen. No calcification or ductal dilatation is seen.

Visualized bowel loops are normal. No evidence of abnormal dilatation/narrowing seen.

Bilateral adrenals appear normal.

Bilateral kidneys are normal in position, size and attenuation. No evidence of hydronephrosis / ureteric dilatation is seen on either side. **A calculus measuring approximately 8.0mm is seen in lower pole calyx of right kidney.**

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www.mahajanimaging.com
CIN : U85199DL1999PTC101010

Patient Name	:	S C Anand	Scan Date	:	07-11-2023
Sex	:	M	Patient ID	:	1218184
Age	:	77Y 5M 26D	Modality	:	MR
Accession No.	:	IP.27457561	Ref Physician	:	Dr. Manoj Kumar

CONTRAST ENHANCED MRI CHEST & WHOLE ABDOMEN

CEMR imaging of the abdomen and pelvis were performed on an advanced 1.5 Tesla, multichannel digital broad-and MR syste using a dedicated multi-channel phased-array surface coil with sagittal & coronal T2 images were obtained and correlated with ax T1 & T2 and fat saturated T1 & T2 weighted images. Additional FFE and diffusion weighted images were also done. Post contra (Omniscan) axial, coronal and sagittal T1 fat sat images were also taken. Class I GBCA (Omniscan 0.5mmol/ml) @ 0.1mmol/kg w administered via a peripheral IV. Serum creatinine 0.89 mg/dL. No contrast reaction was observed.

Clinical profile: *- Shortness of breath.*

FINDINGS

- CHEST

No gross lung parenchymal lesion is seen.

No evidence of mediastinal lymphadenopathy or hilar lymphadenopathy is seen. The vascular structure appear unremarkable. No evidence of any filling defects in the main or the branch pulmonary arteries.

No pleural effusion is seen.

Chest wall appears normal.

- ABDOMEN

Liver – appears enlarged, measuring approximately 17.0cm in longitudinal span of right lobe. lobulated mass / lesion (T2 hyperintense, DW restricted) is seen in the posterior subcapsular an upper part of segment 7 along the course of the right hepatic vein and extending into the hepatic vei and IVC confluence. Mild peripheral enhancement is seen in the delayed arterial / porto-venous phas around this lesion. Findings are indeterminate ? liver lesion ? tumefactive thrombus in the rigl hepatic vein extending into the hepatic IVC. The intrahepatic IVC shows patent lumen. Mild volum redistribution is seen in the liver.

The middle and left hepatic vein show preserved flow signal.

The main portal vein and its right and left branches show intraluminal soft tissue (T2 / DI hyperintense) causing almost total luminal occlusion and extending into the peripheral branche: Peripheral enhancement is seen in along the entire course of the portal vein ? enhancing vas vasorum. The thrombus is also extending inferiorly into the SMV. The splenic is not well delineate Multiple periportal collaterals are noted.

Area of subcapsular non-mass arterial phase enhancement seen bilaterally in the liver parenchym suggesting transient hepatic arterial difference.

Gall bladder – *suboptimally distended and multiple calculi are seen in the lumen.* The wall is not thickene

No evidence of any IHBR or CBD dilatation.

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CIN : U85199DL1999PTC101010

Patient Name	:	S C Anand	Scan Date	:	07-11-2023
Sex	:	M	Patient ID	:	1218184
Age	:	77Y 5M 26D	Modality	:	MR
Accession No.	:	IP.27457561	Ref Physician	:	Dr. Manoj Kumar

Pancreas – appears normal in size, contour and signal with normal peripancreatic fat planes. The pancre duct is not dilated. No focal pancreatic collections or masses are seen. No evidence of pancreatic divisur

Spleen – appears normal in size (9.5cm).

Kidneys – normal in size, contour and position with preserved corticomedullary differentiation. hydronephrosis or focal lesion is seen. The perinephric fat planes are intact. The visualized ureters are dilated.
Right kidney measures approximately 10.2cm in length.
Left kidney measures approximately 9.9cm in length.

Adrenals – appear normal.

Few small volume lymph nodes are seen in the mesentery and left para-aortic regions; these are of uncert pathological significance.

No free fluid is seen in the abdomen.
The urinary bladder and prostate are unremarkable.
There is no free fluid in the pelvis. No significant lymphadenopathy is seen.

IMPRESSION:

The study reveals:

- **Extensive thrombosis of the main and intrahepatic portal vein. Thrombus is seen extending in the superior mesenteric vein.**
- **Elongated lobulated subcapsular mass in a segment 7 postero-superior part ? lesion infiltrati right hepatic vein ? tumefactive thrombus in the right hepatic vein. The hepatic segment of t IVC appears occluded by a thrombus / extension from hepatic vein thrombus / lesion.**
- **The liver shows chronic parenchymal changes.**

Suggest further evaluation with PET studies, serum Alpha-feto protein and histopathology.

Please correlate clinically.

DR. SHOMA MUKERJEE, MD *
(SR. CONSULTANT RADIOLOGIST)
DMC No. 53548

DR. DEVENDRA K. SINGH, DMRD, DNB
(SR. CONSULTANT RADIOLOGIST)
DMC No. 74609

DR. BHAWNA TOKAS, MD
(CONSULTANT RADIOLOGIST)
DMC. No. 39360

DR. AMARDEEP SINGH KHURANA, DNB
(CONSULTANT RADIOLOGIST)
DMC NO. 46746

Note: Please correlate the measurements on the typed report with the images and in case of any discrepancy / doubt, please contact us immediate
This is only a professional opinion and should be correlated clinically. Not valid for medico-legal purpose. A Page 2 of 2

MC-5716

PATIENT NAME : S C ANAND	**REF. DOCTOR :** DR. MANOJ KUMAR	
FLT LT RAJAN DHAL CHARITABLE TRUST IPD SECTOR-B, POCKET-1, ARUNA ASAF ALI MARG NEW DELHI 110070 11-42776222	ACCESSION NO : **0013WK002083** PATIENT ID : FH.1218184 CLIENT PATIENT ID: UID:1218184 ABHA NO :	AGE/SEX : 77 Years Male DRAWN : 07/11/2023 10:45:00 RECEIVED : 07/11/2023 11:09:54 REPORTED : 07/11/2023 20:02:07

CLINICAL INFORMATION :

UID:1218184 REQNO-15316197
IPD-WARD-B1
IPID-138040/23/1301
IPID-138040/23/1301

Test Report Status **Final**	Results	Biological Reference Interval	Units

SPECIALISED CHEMISTRY - HORMONE

ALPHA-FETOPROTEIN, SERUM

ALPHA-FETOPROTEIN	**6644.0 High**	< OR = 7.0	ng/mL

METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY

Comments

NOTE-ALPHA-FETOPROTEIN VALUE RECHECKED.

Interpretation(s)

****End Of Report****

Please visit www.agilusdiagnostics.com for related Test Information for this accession

View Details View Report

Patient Ref. No. 13000002178984

MC-5836

PATIENT NAME : S C ANAND

REF. DOCTOR :DR. MANOJ KUMAR

FLT LT RAJAN DHAL CHARITABLE TRUST IPD
SECTOR-B, POCKET-1, ARUNA ASAF ALI MARG
NEW DELHI 110070
11-42776222

ACCESSION NO : **0013WK003332**
PATIENT ID : FH.1218184
CLIENT PATIENT ID: UID:1218184
ABHA NO :

AGE/SEX :77 Years Male
DRAWN :11/11/2023 05:33:00
RECEIVED : 11/11/2023 06:44:09
REPORTED :11/11/2023 07:51:54

CLINICAL INFORMATION :

UID:1218184 REQNO-15354025
IPD-WARD-B1
IPID-138040/23/1301
IPID-138040/23/1301

Test Report Status **Final**	Results	Biological Reference Interval	Units
COAGULATION			
ACTIVATED PARTIAL THROMBOPLASTIN TIME(APTT),PLASMA			
APTT	**36.8 High**	23.1 - 34.3	SECONDS
METHOD : CLOT DETECTION BY BALL OSCILATION			

Comments

LOW OR HIGH HEMATOCRIT VALUES CAN ALTER PT & APTT VALUE.
KINDLY CORRELATE CLINICALLY.

PROTHROMBIN TIME, CITRATE PLASMA

PROTHROMBIN TIME (PT)	14.6	10.7 - 14.9	SECONDS
METHOD : CLOT DETECTION BY BALL OSCILATION			
INTERNATIONAL NORMALIZED RATIO (INR)	1.17	0.81 - 1.2	RATIO
MEAN PROTHROMBIN TIME OF CONTROL PLASMA (MNPT)	12.8		SECONDS

Interpretation(s)
ACTIVATED PARTIAL THROMBOPLASTIN TIME(APTT),PLASMA-**TEST DESCRIPTION**
The Activated Partial Thromboplastin Time (APTT), a global screening, procedure used primarily to evaluate coagulation abnormalities in the intrinsic path way, will also detect severe functional deficiencies in Factors II, V, X, or Fibrinogen & Inhibitors.
TEST INTERPRETATION
PROLONGED APTT TESTS may be due to:1.Heparin, Coumarin (Warfarin) anticoagulant therapy,2.Inherited or acquired Factor deficiencies,3.A non specific inhibitor such as the lupus anticoagulant(LA)
DECREASE IN APTT determination may be due to : Conjugated estrogen therapy in males and oral contraceptive administration in females,
False Positive-Patients on heparin or heparin substitute,2.Coagulation factor VIII inhibitors.
False Negative-Elevated factor VIII levels, as may be seen in an acute infection or with replacement therapy when someone has Hemophilia A, may shorten the aPTT time, leading to a temporary false negative test for lupus anticoagulant.
INTERFERENCES :a.Insufficient sample.,b.Patients with very increased or decreased haematocrit levels.c.Clotted blood samples.,d.Heparin contamination from intra-venous line.
RECOMMENDATION-Unexpected abnormal APTT results should always be followed by additional coagulation studies to determine the source of abnormal results.
PROTHROMBIN TIME, CITRATE PLASMA-**TEST DESCRIPTION**- Prothrombin Time measures the integrity of the extrinsic pathway and the adequacy of critical coagulation factors involved in it, namely, Factor VII. This test is therefore, used for monitoring oral anticoagulation therapy which lowers the levels of multiple vitamin K dependent coagulation factors in blood (Factors II, VII, IX and X) including Factor VII. The result of PT is expressed as International Normalized Ratio (INR) to neutralize the influence of variable sensitivity of the reagents (thromboplastin) used in the assay by different laboratories
TEST INTERPRETATION- INCREASED PT may be due to:
1.Factor deficiencies,2. Drugs (e.g. Coumarin-type drugs for anticoagulant therapy, salicytes),3. Severe liver damage (e.g. poisoning, hepatitis, cirrhosis),4.Hypofibrinogenemia (Acquired or Inherited),5.Hemorrhagic disease of the newborn.,6 Poor fat absorption (e.g.obstructive jaundice,fistulas,sprue,steatorrhea,celiac disease,colitis,chronic diarrhoea.)
RECOMMENDATION-This is a very sensitive reagent and therefore it is advisable of follow up I.N.R. value rather than P.T. in seconds.The recommended I.N.R. is 2 - 3 for patients on oral anticoagulant in all conditions except mechanical valve replacement and prevention of myocardial infarction where the I.N.R. may be maintained between 2.5-3.5. Please stop anticoagulant therapy if the I.N.R. is > 4.5.

Dr. Rahul Bhardwaj,MD.
Senior Pathologist

View Details View Report

Patient Ref. No. 13000002180276

MC-5836

PATIENT NAME : S C ANAND | **REF. DOCTOR :** DR. MANOJ KUMAR

FLT LT RAJAN DHAL CHARITABLE TRUST IPD
SECTOR-B, POCKET-1, ARUNA ASAF ALI MARG
NEW DELHI 110070
11-42776222

ACCESSION NO : **0013WK002596**
PATIENT ID : FH.1218184
CLIENT PATIENT ID: UID:1218184
ABHA NO :

AGE/SEX : 77 Years Male
DRAWN : 08/11/2023 17:11:00
RECEIVED : 08/11/2023 17:11:51
REPORTED : 08/11/2023 19:04:36

CLINICAL INFORMATION :

UID:1218184 REQNO-15329817
IPD-WARD-B1
IPID-138040/23/1301
IPID-138040/23/1301

Test Report Status **Final**	Results	Biological Reference Interval	Units
COAGULATION			
ACTIVATED PARTIAL THROMBOPLASTIN TIME(APTT),PLASMA			
APTT METHOD : CLOT DETECTION BY BALL OSCILATION	31.2	23.1 - 34.3	SECONDS
Comments LOW OR HIGH HEMATOCRIT VALUES CAN ALTER PT & APTT VALUE. KINDLY CORRELATE CLINICALLY.			
PROTHROMBIN TIME, CITRATE PLASMA			
PROTHROMBIN TIME (PT) METHOD : CLOT DETECTION BY BALL OSCILATION	**15.6 High**	10.7 - 14.9	SECONDS
INTERNATIONAL NORMALIZED RATIO (INR)	**1.27 High**	0.81 - 1.2	RATIO
MEAN PROTHROMBIN TIME OF CONTROL PLASMA (MNPT)	12.8		SECONDS
D-DIMER, PLASMA			
D-DIMER, PLASMA METHOD : LATEX AGGLUTINATION	<0.5	< 0.5	ug/mL FEU

Interpretation(s)
ACTIVATED PARTIAL THROMBOPLASTIN TIME(APTT),PLASMA-**TEST DESCRIPTION**
The Activated Partial Thromboplastin Time (APTT), a global screening, procedure used primarily to evaluate coagulation abnormalities in the intrinsic path way, will also detect severe functional deficiencies in Factors II, V, X, or Fibrinogen & Inhibitors.
TEST INTERPRETATION
PROLONGED APTT TESTS may be due to:1.Heparin, Coumarin (Warfarin) anticoagulant therapy,2.Inherited or acquired Factor deficiencies,3.A non specific inhibitor such as the lupus anticoagulant(LA)
DECREASE IN APTT determination may be due to : Conjugated estrogen therapy in males and oral contraceptive administration in females,
False Positive-Patients on heparin or heparin substitute,2.Coagulation factor VIII inhibitors.
False Negative-Elevated factor VIII levels, as may be seen in an acute infection or with replacement therapy when someone has Hemophilia A, may shorten the aPTT time, leading to a temporary false negative test for lupus anticoagulant.
INTERFERENCES :a.Insufficient sample.,b.Patients with very increased or decreased haematocrit levels.c.Clotted blood samples.,d.Heparin contamination from intra-venous line.
RECOMMENDATION-Unexpected abnormal APTT results should always be followed by additional coagulation studies to determine the source of abnormal results.
PROTHROMBIN TIME, CITRATE PLASMA-**TEST DESCRIPTION**- Prothrombin Time measures the integrity of the extrinsic pathway and the adequacy of critical coagulation factors involved in it, namely, Factor VII. This test is therefore, used for monitoring oral anticoagulation therapy which lowers the levels of multiple vitamin K dependent coagulation factors in blood (Factors II, VII, IX and X) including Factor VII. The result of PT is expressed as International Normalized Ratio (INR) to neutralize the influence of variable sensitivity of the reagents (thromboplastin) used in the assay by different laboratories
TEST INTERPRETATION- INCREASED PT may be due to:
1.Factor deficiencies,2. Drugs (e.g. Coumarin-type drugs for anticoagulant therapy, salicytes),3. Severe liver damage (e.g. poisoning, hepatitis,

Dr. Rahul Bhardwaj,MD.
Senior Pathologist

View Details View Report

Patient Ref. No. 13000002179515

MC-5836

PATIENT NAME : S C ANAND

REF. DOCTOR : DR. MANOJ KUMAR

FLT LT RAJAN DHAL CHARITABLE TRUST IPD
SECTOR-B, POCKET-1, ARUNA ASAF ALI MARG
NEW DELHI 110070
11-42776222

ACCESSION NO : **0013WK002596**
PATIENT ID : FH.1218184
CLIENT PATIENT ID: UID:1218184
ABHA NO :

AGE/SEX : 77 Years Male
DRAWN : 08/11/2023 17:11:00
RECEIVED : 08/11/2023 17:11:51
REPORTED : 08/11/2023 19:04:36

CLINICAL INFORMATION :

UID:1218184 REQNO-15329817
IPD-WARD-B1
IPID-138040/23/1301
IPID-138040/23/1301

Test Report Status **Final**	Results	Biological Reference Interval	Units

cirrhosis),4.Hypofibrinogenemia (Acquired or Inherited),5.Hemorrhagic disease of the newborn.,6 Poor fat absorption (e.g.obstructive jaundice,fistulas,sprue,steatorrhea,celiac disease,colitis,chronic diarrhoea.)
RECOMMENDATION-This is a very sensitive reagent and therefore it is advisable of follow up I.N.R. value rather than P.T. in seconds.The recommended I.N.R. is 2 - 3 for patients on oral anticoagulant in all conditions except mechanical valve replacement and prevention of myocardial infarction where the I.N.R. may be maintained between 2.5-3.5. Please stop anticoagulant therapy if the I.N.R. is > 4.5.
D-DIMER, PLASMA-D-Dimer is a breakdown product of cross-linked fibrin, released following activation of the fibrinolytic system. It is a specific marker for fibrin clot lysis.

Increased D-dimer levels indicate the activation of the coupled blood procoagulant and fibrinolytic mechanisms. Increased D-dimer values are abnormal but do not indicate a specific disease state. Increased levels of D-dimer have been reported in the following cases, deep vein thrombosis (DVT), embolisms, DIC, hemorrhages, surgery, cancers and cirrhosis of liver. The D-dimer levels also increase during pregnancy. In surgical cases, the D-Dimer level generally rises in the first 2 to 3 days post-operatively. If the elevated D-dimer level persists, or tends to rise further, it is a warning sign of an impending or an ongoing thromboembolic episode. Although a negative D-dimer test does not completely rule out thrombosis, it is a useful adjunct in the diagnostic work up. Monitoring of D-Dimer levels in DVT cases on oral anticoagulation is currently being used for determining the risk of recurrence of DVT and therefore, the duration of therapy.

False positive D-Dimer test results may be seen in the presence of high levels of rheumatoid factor (RF), elevated fibrinogen and slightest coagulation of the sample. A negative D-dimer test does not completely rule out thrombosis.

Disclaimer: This test should not be used to exclude deep vein thrombosis (DVT) or pulmonary embolism.

****End Of Report****

Please visit www.agilusdiagnostics.com for related Test Information for this accession

Dr. Rahul Bhardwaj,MD.
Senior Pathologist

View Details View Report

Patient Ref. No. 13000002179515

MC-5836

PATIENT NAME : S C ANAND

REF. DOCTOR :DR. MANOJ KUMAR

FLT LT RAJAN DHAL CHARITABLE TRUST IPD
SECTOR-B, POCKET-1, ARUNA ASAF ALI MARG
NEW DELHI 110070
11-42776222

ACCESSION NO : **0013WK001774**
PATIENT ID : FH.1218184
CLIENT PATIENT ID: UID:1218184
ABHA NO :

AGE/SEX :77 Years Male
DRAWN :06/11/2023 12:29:00
RECEIVED :06/11/2023 13:36:41
REPORTED :06/11/2023 18:39:14

CLINICAL INFORMATION :

UID:1218184 REQNO-15306535
IPD-WARD-B1
IPID-138040/23/1301
IPID-138040/23/1301

Test Report Status **Final**	Results	Biological Reference Interval	Units
COAGULATION			
EXTENDED PREOPERATIVE PANEL			
PROTHROMBIN TIME, CITRATE PLASMA			
PROTHROMBIN TIME (PT) METHOD : CLOT DETECTION BY BALL OSCILATION	14.6	10.7 - 14.9	SECONDS
INTERNATIONAL NORMALIZED RATIO (INR)	1.16	0.81 - 1.2	RATIO
MEAN PROTHROMBIN TIME OF CONTROL PLASMA (MNPT)	12.8		SECONDS
ACTIVATED PARTIAL THROMBOPLASTIN TIME (APTT),PLASMA			
APTT METHOD : CLOT DETECTION BY BALL OSCILATION	28.2	23.1 - 34.3	SECONDS

Comments

LOW OR HIGH HEMATOCRIT VALUES CAN ALTER PT & APTT VALUE.
KINDLY CORRELATE CLINICALLY.

Interpretation(s)

PROTHROMBIN TIME, CITRATE PLASMA-**TEST DESCRIPTION-** Prothrombin Time measures the integrity of the extrinsic pathway and the adequacy of critical coagulation factors involved in it, namely, Factor VII. This test is therefore, used for monitoring oral anticoagulation therapy which lowers the levels of multiple vitamin K dependent coagulation factors in blood (Factors II, VII, IX and X) including Factor VII. The result of PT is expressed as International Normalized Ratio (INR) to neutralize the influence of variable sensitivity of the reagents (thromboplastin) used in the assay by different laboratories

TEST INTERPRETATION- INCREASED PT may be due to:

1.Factor deficiencies,2. Drugs (e.g. Coumarin-type drugs for anticoagulant therapy, salicytes),3. Severe liver damage (e.g. poisoning, hepatitis, cirrhosis),4.Hypofibrinogenemia (Acquired or Inherited),5.Hemorrhagic disease of the newborn.,6 Poor fat absorption (e.g.obstructive jaundice,fistulas,sprue,steatorrhea,celiac disease,colitis,chronic diarrhoea.)

RECOMMENDATION-This is a very sensitive reagent and therefore it is advisable of follow up I.N.R. value rather than P.T. in seconds.The recommended I.N.R. is 2 - 3 for patients on oral anticoagulant in all conditions except mechanical valve replacement and prevention of myocardial infarction where the I.N.R. may be maintained between 2.5-3.5. Please stop anticoagulant therapy if the I.N.R. is > 4.5.

ACTIVATED PARTIAL THROMBOPLASTIN TIME(APTT),PLASMA-**TEST DESCRIPTION**

The Activated Partial Thromboplastin Time (APTT), a global screening, procedure used primarily to evaluate coagulation abnormalities in the intrinsic path way, will also detect severe functional deficiencies in Factors II, V, X, or Fibrinogen & Inhibitors.

TEST INTERPRETATION

PROLONGED APTT TESTS may be due to:1.Heparin, Coumarin (Warfarin) anticoagulant therapy,2.Inherited or acquired Factor deficiencies,3.A non specific inhibitor such as the lupus anticoagulant(LA)

DECREASE IN APTT determination may be due to : Conjugated estrogen therapy in males and oral contraceptive administration in females,

False Positive-Patients on heparin or heparin substitute,2.Coagulation factor VIII inhibitors.

False Negative-Elevated factor VIII levels, as may be seen in an acute infection or with replacement therapy when someone has Hemophilia A, may shorten the aPTT time, leading to a temporary false negative test for lupus anticoagulant.

Dr. Rahul Bhardwaj,MD.
Senior Pathologist

View Details View Report

Patient Ref. No. 13000002178664

MC-5836

PATIENT NAME : S C ANAND

REF. DOCTOR : DR. MANOJ KUMAR

FLT LT RAJAN DHAL CHARITABLE TRUST IPD
SECTOR-B, POCKET-1, ARUNA ASAF ALI MARG
NEW DELHI 110070
11-42776222

ACCESSION NO : **0013WK001774**
PATIENT ID : FH.1218184
CLIENT PATIENT ID: UID:1218184
ABHA NO :

AGE/SEX : 77 Years Male
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Test Report Status **Final**	Results	Biological Reference Interval	Units

INTERFERENCES :a.Insufficient sample.,b.Patients with very increased or decreased haematocrit levels.c.Clotted blood samples.,d.Heparin contamination from intra-venous line.
RECOMMENDATION-Unexpected abnormal APTT results should always be followed by additional coagulation studies to determine the source of abnormal results.

Dr. Rahul Bhardwaj,MD.
Senior Pathologist

View Details View Report

Patient Ref. No. 13000002178664

MC-5836

PATIENT NAME : S C ANAND

REF. DOCTOR :DR. MANOJ KUMAR

FLT LT RAJAN DHAL CHARITABLE TRUST IPD
SECTOR-B, POCKET-1, ARUNA ASAF ALI MARG
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ACCESSION NO : **0013WK001774**
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Test Report Status Final	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.99	0.0 - 1.2	mg/dL
BILIRUBIN, DIRECT	**0.58 High**	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT	0.41	0.00 - 1.00	mg/dL
TOTAL PROTEIN	7.4	6.4 - 8.3	g/dL
ALBUMIN	4.3	3.20 - 4.60	g/dL
GLOBULIN	3.1	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.4	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	**88 High**	UPTO 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**67 High**	UP TO 45	U/L
ALKALINE PHOSPHATASE	**291 High**	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	**609 High**	8 - 61	U/L
LACTATE DEHYDROGENASE	**247 High**	135 - 225	U/L
EXTENDED PREOPERATIVE PANEL			
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	**274 High**	82 - 99	mg/dL
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	14	8 - 23	mg/dL
CREATININE EGFR- EPI			
CREATININE	0.89	0.70 - 1.20	mg/dL
AGE	77		years
GLOMERULAR FILTRATION RATE (MALE)	88.26		mL/min/1.73m2
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	**134 Low**	136- 145	mmol/L
POTASSIUM, SERUM	4.58	3.50- 5.10	mmol/L
CHLORIDE, SERUM	**93 Low**	98 - 107	mmol/L

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